

PLAN NUMBER	PPO 90		PPO 80	
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Annual Medical Out-of-Pocket Limit²				
Individual/Individual in Family/Family	\$2,000/\$2,000/\$6,000	Unlimited	\$3,000/\$3,000/\$9,000	Unlimited
Annual Medical Deductible² - Plan Deductible Applies Unless Otherwise Stated				
Individual/Individual in Family/Family	\$500/\$500/\$1,500	\$1,000/\$1,000/\$3,000	\$750/\$750/\$2,250	\$1,500/\$1,500/\$4,500
Coinsurance, After Deductible is Met				
Plan Pays:	90% (After Deductible)	50% Coinsurance (After Deductible)	80% (After Deductible)	50% Coinsurance (After Deductible)
Physician/Diagnostic Services				
Preventive Care	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered
Primary Care Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Specialist Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum
Inpatient Hospital Services				
Inpatient Hospitalization	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day
Outpatient Services				
Outpatient Surgery	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum
Outpatient Lab and Imaging	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum
Emergency Services				
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)	
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)	
Urgent Care				
Urgent Care Visits	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Mental Health and Substance Abuse				
Inpatient Mental Health	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

³A total of \$250 credits for each member in your family are available to lower your deductible. Please see supplementary plan documents for more information.

⁴\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

PLAN NUMBER		PPO 90		PPO 80	
GENERAL PLAN INFORMATION		IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Mental Health and Substance Abuse (Continued)					
Outpatient Mental Health Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	
Other Outpatient Mental Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	
Other Services					
Acupuncture	10% Coinsurance (After Deductible)	Not Covered	20% Coinsurance (After Deductible)	Not Covered	
Chiropractor Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	
Hearing Aids	\$1,500 Maximum Benefit per Ear, Every 36 Months		\$1,500 Maximum Benefit per Ear, Every 36 Months		
Fertility Benefits	WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption (After Deductible)		WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption (After Deductible)		
PRESCRIPTION DRUG BENEFITS		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Prescription Drug Out-of-Pocket Limit					
Individual/Individual in Family/Family	\$2,000/\$2,000/\$4,000 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited	
Prescription Drug Deductible					
Per Individual	\$0		\$0		
Prescription Drug Formulary					
Formulary (Covered Drugs)	National 3-Tier		National 3-Tier		
Retail		30-Day Supply		30-Day Supply	
Generic	\$5 min Copay/ or 20% up to a \$25 Max Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required	
Brand (Formulary/Preferred)			\$20 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)			\$35 Copay (Deductible Waived)		
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		Same as Retail Brand		
Mail Order		90-Day Supply		90-Day Supply	
Generic	\$5 Copay (Deductible Waived)	Paper claim submission required	\$20 Copay (Deductible Waived)	Paper claim submission required	
Brand (Formulary/Preferred)			\$40 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)			\$70 Copay (Deductible Waived)		
Specialty Rx (Specialty Pharmacy Only; 30-day supply)			\$70 Copay (Deductible Waived)		

²The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the EOC, the EOC will prevail.



PLAN NUMBER		ANTHEM BLUE CROSS				KAISER PERMANENTE	
		CDHP PPO 90		CDHP PPO 60		CDHP DHMO 90	CDHP DHMO 60
GENERAL PLAN INFORMATION		IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit							
Individual/Individual in Family/Family	\$3,000/\$6,000/\$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	\$8,700/\$8,700/\$17,400 (Combined Medical & Rx Out-of-Pocket Max) ²	Unlimited	\$3,500/\$3,500/\$7,000 (Combined Medical & Rx Out-of-Pocket Max) ³	\$6,250/\$6,250/\$12,500 (Combined Medical & Rx Out-of-Pocket Max) ²	
Annual Combined Medical Deductible and Prescription Drug Deductible - Plan deductible applies unless otherwise stated							
Individual/Individual in Family/Family	\$1,750/\$3,500/\$3,500	\$4,000/\$8,000/\$8,000	\$3,500/\$3,500/\$7,000 ²	\$5,000/\$5,000/\$10,000 ²	\$1,750/\$3,500/\$3,500 ²	\$4,500/\$4,500/\$9,000 ²	
Plan Information							
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	
Referrals Required?	No		No		Yes	Yes	
Plan Coinsurance	Plan Pays 90% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 60% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 90% (After Deductible)	Plan Pays 60% (After Deductible)	
Health Savings Account (HSA) Compatibility							
HSA-Compatible Plan:	Yes		Yes		Yes	Yes	
2027 Individual Maximum Contribution:	\$4,500		\$4,500		\$4,500	\$4,500	
2027 Family Maximum Contribution:	\$9,000		\$9,000		\$9,000	\$9,000	
Over 55 HSA Contribution Catch-Up:	\$1,000		\$1,000		\$1,000	\$1,000	
Physician/Diagnostic Services							
Preventive Care	\$0 (Deductible Waived)	50% Coinsurance (After Deductible)	\$0 (Deductible Waived)	50% Coinsurance (After Deductible)	\$0 (Deductible Waived)	\$0 (Deductible Waived)	
Primary Care Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	\$40 Copay (After Deductible)	
Specialist Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	\$40 Copay (After Deductible)	
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible; Not to Exceed \$150 per Procedure)	
Inpatient Hospital Services							
Inpatient Hospitalization	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	
Outpatient Services							
Outpatient Surgery	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	
Outpatient Lab and Imaging	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	
Emergency Services							
Ambulance Services	10% Coinsurance (After Deductible)		40% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	
Emergency Room	10% Coinsurance (After Deductible)		40% Coinsurance (After Deductible; \$250 Copay, Waived if Admitted)		10% Coinsurance (After Deductible)	\$250 Copay (After Deductible)	

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.

³The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.



PLAN NUMBER		ANTHEM BLUE CROSS				KAISER PERMANENTE	
		CDHP PPO 90		CDHP PPO 60		CDHP DHMO 90	CDHP DHMO 60
GENERAL PLAN INFORMATION		IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK ONLY	IN-NETWORK ONLY
Urgent Care							
Urgent Care Visits		10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	\$40 Copay (After Deductible)
Mental Health and Substance Abuse							
Inpatient Mental Health		10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit		10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	\$40 Copay (After Deductible)
Other Outpatient Mental Health Services		10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Other Services							
Acupuncture		10% Coinsurance (After Deductible), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	40% Coinsurance (After Deductible), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	N/A	N/A
Chiropractor Services		10% Coinsurance (After Deductible), maximum of 30 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	40% Coinsurance (After Deductible), maximum of 30 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	N/A	N/A
Hearing Aids		\$1,500 Maximum Benefit per Ear, Every 36 Months		\$1,500 Maximum Benefit per Ear, Every 36 Months		N/A	N/A
Fertility Benefits		WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption (After Deductible)		WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption (After Deductible)		3-Cycle, Unlimited Rx (After Deductible)	3-Cycle, Unlimited Rx (After Deductible)
PRESCRIPTION DRUG BENEFITS		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Prescription Drug Out-of-Pocket Limit							
Individual/Individual in Family/Family		Combined with Medical		Combined with Medical		Combined with Medical	Combined with Medical
Prescription Drug Deductible							
Individual/Individual in Family/Family		Combined with Medical		Combined with Medical		Combined with Medical	Combined with Medical
Prescription Drug Formulary							
Formulary (Covered Drugs)		National 4-Tier		National 4-Tier		CA Commercial 3-Tier	CA Commercial 3-Tier
Retail		30-Day Supply		30-Day Supply		30-Day Supply	30-Day Supply
Generic		\$10 Copay (After Deductible)		\$20 Copay (After Deductible)		\$10 Copay (After Deductible)	\$15 Copay (After Deductible)
Brand (Formulary/Preferred)		\$30 Copay (After Deductible)		\$45 Copay (After Deductible)		\$30 Copay (After Deductible)	\$35 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)		\$30 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$60 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$30 Copay (After Deductible)	\$35 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		20% Coinsurance (After Deductible; Not to Exceed \$150)		20% Coinsurance (After Deductible; Not to Exceed \$150)		20% Coinsurance (After Deductible; Not to Exceed \$150)	30% Coinsurance (After Deductible; Not to Exceed \$250)
Mail Order		90-Day Supply		90-Day Supply		100-Day Supply	100-Day Supply
Generic		\$20 Copay (After Deductible)		\$40 Copay (After Deductible)		\$20 Copay (After Deductible)	\$30 Copay (After Deductible)
Brand (Formulary/Preferred)		\$60 Copay (After Deductible)		\$90 Copay (After Deductible)		\$60 Copay (After Deductible)	\$70 Copay (After Deductible)
Brand (Non-Formulary/Preferred)		\$60 Copay (After Deductible)	Paper claim submission required	\$120 Copay (After Deductible)	Paper claim submission required	\$60 Copay (After Deductible)	\$70 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		20% (After Deductible; Not to Exceed \$150)		20% (After Deductible; Not to Exceed \$150)		20% Coinsurance (After Deductible; Not to Exceed \$150)	30% Coinsurance (After Deductible; Not to Exceed \$250)

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the EOC, the EOC will prevail.

**CSEBO MEDICAL INSURANCE
HMO COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027**



CARRIER	ANTHEM BLUE CROSS	KAISER PERMANENTE
PLAN NAME	SELECT HMO 10	HMO 10
GENERAL PLAN INFORMATION	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit¹		
Individual/Individual in Family/Family	\$1,500/\$1,500/\$4,500	\$1,500/\$1,500/\$3,000
Annual Medical Deductible		
Individual/Individual in Family/Family	\$0	\$0
Plan Information		
Type of Plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Referrals Required?	Yes	Yes
Physician/Diagnostic Services		
Preventive Care	No Charge	No Charge
TeleMedicine (Audio/Video Visits)	No Charge	No Charge
Primary Care Office Visit	\$10 Copay	\$10 Copay
Specialist Office Visit	\$10 Copay	\$10 Copay
Diagnostic X-Ray and Lab Tests	No Charge	No Charge
Advanced Imaging	No Charge	No Charge
Inpatient Hospital Services		
Inpatient Hospitalization	No Charge	No Charge
Outpatient Services		
Outpatient Surgery	No Charge	\$10 Copay per Procedure
Outpatient Lab and Imaging	No Charge	No Charge
Emergency Services		
Ambulance Services	No Charge	\$50 per trip
Emergency Room	\$50 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)
Urgent Care		
Urgent Care Visits	\$10 Copay	\$10 Copay
Mental Health and Substance Abuse		
Inpatient Mental Health	No Charge	No Charge
Outpatient Mental Health Office Visit	\$10 Copay	\$10 Copay
Other Outpatient Mental Health Services	No Charge	No Charge

¹The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per-person out-of-pocket maximum. In addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.

**CSEBO MEDICAL INSURANCE
HMO COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027**



CARRIER		ANTHEM BLUE CROSS	KAISER PERMANENTE
PLAN NAME		SELECT HMO 10	HMO 10
GENERAL PLAN INFORMATION		IN-NETWORK ONLY	IN-NETWORK ONLY
Other Services			
Acupuncture	\$10 copay for medically necessary acupuncture, referral required	\$10 copay for medically necessary acupuncture, referral required	
Chiropractic Services	\$10 copay, rehabilitative care only, referral required, per 60-day period	\$10 Copay, Combined 30 Visits per 12-Month Period for Acupuncture and Chiropractic Services, Referral Not Required	
Hearing Aids	One per Ear, Every 36 Months	\$1,500 per Ear, Every 36 Months	
Infertility Benefits	3-Cycle, Unlimited Rx	3-Cycle, Unlimited Rx	
PRESCRIPTION DRUG BENEFITS		IN-NETWORK ONLY	
Annual Prescription Drug Out-of-Pocket Limit			
Individual/Family	Combined with Medical		Combined with Medical
Prescription Drug Deductible			
Per Individual	\$0		\$0
Prescription Drug Formulary			
Formulary (Covered Drugs)	National 3-Tier		CA Commercial 2-Tier
Retail		30-Day Supply	30-Day Supply
Generic	\$10 Copay	\$10 Copay	
Brand (Formulary/Preferred)	\$20 Copay	\$20 Copay	
Brand (Non-Formulary/Non-Preferred)	\$20 Copay	\$20 Copay	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$20 Copay	\$20 Copay	
Mail Order		90-Day Supply	100-Day Supply
Generic	\$20 copay	\$20 Copay	
Brand (Formulary/Preferred)	\$40 copay	\$40 Copay	
Brand (Non-Formulary/Non-Preferred)	\$40 copay	\$40 Copay	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$40 copay	Retail Only	

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CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2027 - 12/31/2027



PLAN NAME		DELTA DENTAL PPO ¹	
GENERAL PLAN INFORMATION		IN-NETWORK	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Calendar Year Annual Maximum		\$3,000	\$3,000
Incentive Levels			
Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%.		Plan pays: 70/80/90/100%	Plan pays: 70/80/90/100%
Diagnostic and Preventive Benefits		Incentive Level Coverage	
Prophylaxis (Cleaning) Treatments	Plan pays: 100%; limited to 2 per calendar year ²	Plan pays: 100%; limited to 2 per calendar year ²	
Oral Examinations	Plan pays: 100%; limited to 2 per calendar year ²	Plan pays: 100%; limited to 2 per calendar year ²	
Full-Mouth X-Rays	Plan pays: 100%; limited to 1 per 36 months ²	Plan pays: 100%; limited to 1 per 36 months ²	
Bitewing X-Rays	Plan pays: 100%; upon provider request, maximum of 2 per calendar year ²	Plan pays: 100%; upon provider request, maximum of 2 per calendar year ²	
Periodontal Scaling and Root Planing	Plan pays: 100%; limited to 1 each quadrant every 24 months	Plan pays: 100%; limited to 1 each quadrant every 24 months	
Fluoride Treatments	Plan pays: 100% limited to 2 per calendar year ²	Plan pays: 100% limited to 2 per calendar year ²	
Space Maintainers	Plan pays: 100% ²	Plan pays: 100% ²	
Basic Benefits		Incentive Level Coverage	
Oral Surgery - Extractions	Plan pays: 70/80/90/100%; limited to once per tooth per lifetime	Plan pays: 70/80/90/100%; limited to once per tooth per lifetime	
Oral Surgery - Other Surgical Procedures	Plan pays: 50-100% depending on procedure	Plan pays: 50-100% depending on procedure	

¹Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

²Cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2027 - 12/31/2027



PLAN NAME		DELTA DENTAL PPO ¹	
GENERAL PLAN INFORMATION		IN-NETWORK	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Basic Benefits (continued)		Incentive Level Coverage	
Restorative Procedures - Amalgam, Silicate or Composite (Resin)		Plan pays: 70/80/90/100%; limited to once per surface, per tooth within a 2 year period	Plan pays: 70/80/90/100%; limited to once per surface, per tooth within a 2 year period
Restorations (Fillings)		Plan pays: 70/80/90/100%; limitations apply	Plan pays: 70/80/90/100%; limitations apply
Endodontic Treatments		Plan pays: 70/80/90/100%; limitations apply	Plan pays: 70/80/90/100%; limitations apply
Periodontic Treatment		Plan pays: 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan pays: 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.
Sealants			
Crowns, Inlays, Onlays and Cast Restoration Benefits		Incentive Level Coverage	
Crowns, Inlays, Onlays and Cast Restoration		Plan pays: 70/80/90/100%; service on the same tooth only once every 5 years	Plan pays: 70/80/90/100%; service on the same tooth only once every 5 years
Prosthodontic Benefits		Incentive Level Coverage	
Implants		Plan pays: 50%; limited to once every 5 years	Plan pays: 50%; limited to once every 5 years
Removable - Partial Dentures, Full Dentures		Plan pays: 50%; limited to once every 5 years	Plan pays: 50%; limited to once every 5 years
Fixed - Inlays, Onlays, Bridges		Plan pays: 50%; limited to once every 5 years	Plan pays: 50%; limited to once every 5 years
Orthodontia Benefits		Incentive Level Coverage	
Coverage Eligibility		Child Only	Child Only
Coverage Percentage		Plan pays: 100%	Plan pays: 100%
Lifetime Individual Maximum		\$3,000	\$3,000

¹Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

²Cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

CSEBO VISION INSURANCE
VSP PPO COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027



GENERAL PLAN INFORMATION		BASE		BUY-UP	
Service Frequencies		In-Network	Out-of-Network	In-Network	Out-of-Network
	Exam Every	12 months	12 months	12 months	12 months
	Lenses Every	12 months	12 months	12 months	12 months
	Frame Every	24 months	24 months	12 months	12 months
Benefits					
	Copays	\$10	\$10	\$10	\$10
	Examination	Covered after copay	up to \$45	Covered after copay	up to \$45
	Contact Lens Fitting	Covered After Copay	Up To \$45	Covered After Copay	Up To \$45
	Retinal Imaging	Up to \$39, After \$10 Copay	Up To \$45	Covered After Copay	Up To \$45
Prescription Glasses					
	Coverage	Contacts <u>OR</u> Glasses		Contacts <u>AND</u> Glasses	
	Frame Allowance	\$200	up to \$70	\$300	Up To \$70
	Contacts (instead of glasses)	\$200	up to \$90	\$300	Up To \$105
Lenses					
	Single Vision	Covered after copay	up to \$30	Covered after copay	up to \$30
	Lined Bifocal	Covered after copay	up to \$50	Covered after copay	up to \$50
	Lined Trifocal	Covered after copay	up to \$65	Covered after copay	up to \$65
Lens Enhancements (Negotiated Member Share Savings of 20-25%) ¹					
	Anti-Reflective Coatings	\$41 - \$85	Provider rate	\$40 copay ²	Provider rate
	Custom Progressive Lenses	\$150 - \$175	Provider rate	\$150 - \$175	Provider rate
	Edge Polish	\$36	Provider rate	\$36	Provider rate
	Light Filter	\$15	Provider rate	\$15	Provider rate
	High Index Lenses	\$50 - \$125	Provider rate	\$50 - \$125	Provider rate
	Light-Reactive Lenses	\$75	Provider rate	\$75	Provider rate
	Polarized Lenses	\$57 - \$101	Provider rate	\$57 - \$101	Provider rate
	Impact-Resistant Lenses	\$31 - \$35	Provider rate	\$31 - \$35	Provider rate
	Premium Progressive Lenses	\$95 - \$105	Provider rate	\$95 - \$105	Provider rate
	Scratch-Resistant Coating	\$17 - \$33	Provider rate	\$17 - \$33	Provider rate
	Standard Progressive Lenses	No Charge	Provider rate	No Charge	Provider rate
	Tinted (Colored) Lenses	\$15 - \$17	Provider rate	\$15 - \$17	Provider rate
	UV Protection	\$16	Provider rate	\$16	Provider rate

¹Costco Optical pricing already includes member savings.

²Costco Optical pricing may vary.

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EMPLOYEE ASSISTANCE PROGRAM
OPTUM
EFFECTIVE 1/1/2027 - 12/31/2027



TYPE OF PLAN		EMPLOYEE ASSISTANCE PROGRAM ¹
GENERAL PLAN INFORMATION		IN-NETWORK BENEFITS
Contact Information - 24-Hours per Day/7-Days per Week		
	Phone	(888) 444-8624
	Web	www.liveandworkwell.com
	Access Code	CSEBO
EAP Benefits		Copays/Coinsurance
	5 Face-To-Face Visits per Problem per Year	\$0
Covered Visits²		Copays/Coinsurance
	Child/Parenting Services	\$0
	Adult/Elder Support	\$0
	Financial Resources	\$0
	Legal/Mediation Resources	\$0
	Chronic Condition Support	\$0
	Life Learning/Educational Support Services	\$0
	Convenience Services	\$0

¹The Employee Assistance Program is a benefit that is provided to each benefit-eligible employee of the OUHSD at no charge. You do not need to "select" this plan, eligible employees will automatically have access to these benefits.

²You must obtain prior-authorization through Optum prior to face-to-face consulting services. Please contact (888) 444-8624 to obtain authorization for face-to-face visits and for access to the full WorkLife program.

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